MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2005

Connecticut General Life Insurance Company
3900 East Mexico Avenue
Suite 1100
Denver, Colorado 80210

NAIC Group Code 0901
NAIC Company Code 62308

EXAMINATION PERFORMED BY
DIVISION OF INSURANCE STAFF
COLORADO DEPARTMENT OF REGULATORY AGENCIES
STATE OF COLORADO

Connecticut General Life Insurance Company
3900 East Mexico Avenue
Suite 1100
Denver, Colorado 80210

LIMITED MARKET CONDUCT EXAMINATION REPORT as of December 31, 2005

Examination Performed by

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

David M. Tucker, AIE, FLMI, ACS

John E. Bell

Colorado Market Conduct Examiners

April 12, 2007

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Morrison:

This limited market conduct examination of Connecticut General Life Insurance Company was conducted pursuant to §§ 10-1-203, 10-1-204, 10-1-205(8) and 10-3-1106, C.R.S., which authorize the Commissioner of Insurance to examine insurance companies. We examined the Company's records at the principal office of its affiliate, CIGNA HealthCare of Colorado, Inc., at 3900 East Mexico Avenue, Denver, Colorado, 80210 and at the Colorado Division of Insurance offices at 1560 Broadway, Denver, Colorado, 80202. The market conduct examination covered the period from January 1, 2005, through December 31, 2005.

The following market conduct examiners respectfully submit the results of the examination.

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

David M. Tucker, AIE, FLMI, ACS

John E. Bell

TABLE OF CONTENTS

SECTION **PAGE**

I. COMPANY PROFILE.....5

II. PURPOSE AND SCOPE OF EXAMINATION.....6

III. EXAMINERS' METHODOLOGY.....7

IV. EXAMINATION REPORT SUMMARY.....10

V. FACTUAL FINDINGS.....12

E. Contract Forms.....13
J. Claims.....17
K. Utilization Review.....24

VI. SUMMARY OF ISSUES AND RECOMMENDATIONS.....35

VII. EXAMINATION REPORT SUBMISSION.....36

COMPANY PROFILE

The following profile is based on information provided by the Company:

Connecticut General Life Insurance Company ("CGLIC" or "Company") operates under a charter that was granted by the General Assembly of the State of Connecticut on June 22, 1865. The Company was organized and commenced business in October 1865. On December 19, 1967, the Company became a wholly owned subsidiary of the Connecticut General Insurance Corporation ("CGIC"), a holding company, chartered in 1967. In July 1981, CGIC changed its name to Connecticut General Corporation ("CGC").

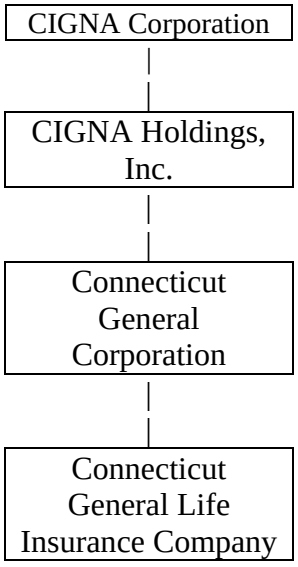
On November 6, 1981, the respective Boards of Directors of CGC and INA Corporation (:INA"), an insurance holding company, approved a plan of merger. That merger was consummated on March 31, 1982, with the creation of CIGNA Corporation ("CIGNA") as the ultimate parent company of CGC and INA. CIGNA Holdings, Inc. ("CIGNA Holdings"), a Delaware corporation, was established on November 3, 1982. On October 1, 1983, CGC became a direct subsidiary of CIGNA Holdings, which in turn is wholly owned by CIGNA.

The Company's principle products include group life, accident and health insurance, and professional services provided to sponsors of qualified pension, profit-sharing and retirement savings plans. CGLIC is domiciled in the State of Connecticut and licensed in all fifty (50) states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Canada and Taiwan. The Company was licensed and began operation in Colorado on March 1, 1977.

CGLIC's gross written premium for calendar year 2005 was $135,245,000 for all accident and health insurance business in Colorado. The Company's market share in Colorado was 1.84% of all accident and health insurance business written in Colorado.

CGLIC's NAIC group code and company number are 901 and 62308 respectively.

A relational organization chart is attached.



PURPOSE AND SCOPE

State market conduct examiners with the Colorado Division of Insurance, (Division) in accordance with Colorado insurance law, §§ 10-1-201, 10-1-203, 10-1-204, 10-1-205(8) and 10-3-1106, C.R.S., which empowers the Commissioner to examine any entity engaged in the business of insurance, reviewed certain business practices of the Company. The findings in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance laws related to health insurance companies. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

The examiners conducted the examination in accordance with procedures developed by the Division, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained and/or submitted by the Company. The limited market conduct examination covered the period from January 1, 2005, through December 31, 2005.

The examination included review of the following:

Company Operations and Management
Contract Forms
Claims
Utilization Review

The final examination report is a report written by exception. References to additional practices, procedures, or files that did not contain any improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to small and large group health insurance laws as they pertained to insurance companies. Examination findings may result in administrative action by the Division. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance product.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g., timeliness of claims payment), and if one or more of the samples yielded an exception rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws. For this examination, special emphasis was given to the laws and regulations as shown in Exhibit 1.

During the examination, the examiners met with the Company examination coordinator to discuss the examination process. One of the topics discussed was that although CIGNA HealthCare of Colorado, Inc. and CGLIC are separate companies, there are certain policies, procedures and forms that are common to both companies.

Therefore, it was agreed that in cases involving claims and utilization review the Division would "deem" the findings to be applicable to both companies, even though the actual findings may have been identified in only one of the companies.

Exhibit 1

Statute/Regulation	Concerning
Section 10-1-128, C.R.S.	Fraudulent insurance acts - immunity for furnishing information relating to suspected insurance fraud - legislative declaration.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-8-513, C.R.S.	Eligibility for coverage under the program.
Section 10-8-521, C.R.S.	Notice to residents.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-103.5, C.R.S.	Payment of Premiums – required term in contract.
Section 10-16-104, C.R.S.	Mandatory coverage provisions.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – rules.
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials – legislative declaration – definitions.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-214, C.R.S.	Group sickness and accident insurance.
Section 10-16-704, C.R.S.	Network adequacy – rules – legislative declaration – repeal.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Insurance Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Private Passenger Automobile Forms, commercial Automobile with Individually-owned Private Passenger Automobile-Type Endorsement Forms, Claims-made Liability Forms and Preneed Funeral Contracts
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Insurance Regulation 4-2-5	Hospital Definition
Insurance Regulation 4-2-6	Concerning the Definition of the Term "Complications of Pregnancy" for Use in Accident and Health Insurance Contracts and Certificates
Insurance Regulation 4-2-8	Required Health Insurance Benefits for Home Health Services and Hospice Care
Insurance Regulation 4-2-11	Rate Filing and Annual Report Submissions Health Insurance

Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation Of Health Plan Claims Involving Utilization Review
Insurance Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Insurance Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Insurance Regulation 4-6-5	Concerning Implementation of Basic and Standard Health Benefit Plans
Insurance Regulation 4-6-9	Conversion Coverage

Company Operations and Management

The examiners reviewed Company management and administrative controls, the certificate of authority, record retention, underwriting guidelines, and timely cooperation with the examination process.

Audits and Examinations

The Company was the subject of a previous limited market conduct examination dated March 25, 1998, which covered the period January 1, 1995 through December 31, 1996.

Contract Forms

The examiners reviewed the following forms:

- The Company's Basic and Standard PPO Plans, copayment schedules and schedules of benefits;
- The Company's most commonly sold PPO group certificates;
- The Company's PPO conversion certificates, application/enrollment forms, and supporting documents; and
- The Company's group and employee PPO applications/enrollment forms and supporting documents.

These plans and related documents were issued and/or certified with the Division between January 1, 2005 and December 31, 2005.

Claims

In order to determine the Company's compliance with Colorado's prompt payment of claims law and the proper and accurate payment of claims, the examiners reviewed the following random samples:

- 100 paid claims;
- 100 denied claims;
- 50 electronic claims paid or denied beyond thirty (30) days or longer from claim received date;
- 50 non-electronic claims paid or denied beyond forty-five (45) days or longer from claim received date;
- 50 claims paid or denied beyond ninety (90) days or longer from claim received date.

Utilization Review

During the examination, the examiners met with the Company examination coordinator to discuss the examination process. One of the topics discussed was that although CIGNA HealthCare of Colorado, Inc. and CGLIC, Inc. are different companies, there are certain policies, procedures and forms that are common to both companies. Therefore, it was agreed that in the area of utilization review, the examiners would "deem" the findings to be applicable to the company, even though the actual findings were identified in the examination of CIGNA HealthCare of Colorado, Inc. Accordingly, the utilization review portion of the CIGNA HealthCare of Colorado, Inc. examination report dated April 12, 2007, is "deemed" to apply to the Company.

The examiners reviewed the Company's utilization management program including policies and procedures. The examiners selected a random sample of fifty (50) utilization review (UR) denial decision files from a summarized population of ninety-six (96). These sample files were reviewed for the Company's overall UR handling practices, as well as timeliness of completing the review and communication of the decisions to the appropriate persons in order to determine compliance with Colorado insurance law.

In addition, the examiners reviewed a random sample of fifty (50) first level appeal files from a summarized population of ninety (90) files and the entire population of nine (9) voluntary second level appeal files in order to determine compliance with Colorado insurance law.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of thirteen (13) findings in which the Company did not appear to be in compliance with Colorado insurance laws. The following is a summary of the examiners' findings.

Operations and Management: The examiners identified no areas of concern in their review of the Company's operations/management.

Contract Forms: The examiners identified two (2) areas of concern in their review of the Company's contract forms (including evidence of coverage forms, employer/employee applications, group service contracts, and riders):

- **Failure of forms to properly define and/or list the mandated transplant benefits in its Basic and Standard health benefit plan certificates.**

- **Failure to properly title its Basic health benefit plan certificates.**

Claims: The examiners identified three (3) areas of concern in their review of the claims handling practices of the Company:

- **Failure, in some instances, to pay, deny, or settle claims within the time frames required by Colorado insurance law.**

- **Failure, in some instances, to pay interest and/or penalty on claims not processed within the time frames required by Colorado insurance law.**

- **Failure, in some instances, to pay eligible claims.**

Utilization Review: The examiners identified eight (8) areas of concern in their review of the Company's Utilization Review procedures.

- **Failure, in some instances, to provide written notification of standard utilization review adverse determinations.**

- **Failure, in some instances, to pay interest and/or penalty on claims not processed within the time frames required by Colorado insurance law.**

- **Failure, in some instances, to provide the title and qualifying credentials of the physician reviewer in first level appeal notification letters.**

- **Failure, in some instances, to consult with an appropriate clinical peer in reviewing first level utilization review appeals.**

- **Failure to disclose and/or provide the names, titles and/or credentials of the voluntary second level utilization review panel.**

- **Failure, in some instances, to ensure that a majority of the voluntary second level appeal review panel is comprised of health care professionals with appropriate expertise.**

- **Failure, in some instances, to provide notice of voluntary second level review scheduling to covered persons at least twenty (20) days prior to the scheduled review date.**

- **Failure, in some instances, to not discourage covered persons (or their representative) from requesting a face-to-face voluntary second level utilization review meeting.**

Results of previous market conduct examinations are available on the Division's website at www.dora.state.co.us/insurance or by contacting the Division.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

CONTRACT FORMS

Issue E1: Failure of forms to properly define and/or list the mandated transplant benefits in its Basic and Standard health benefit plan certificates.

Colorado Insurance Regulation 4-6-5, Concerning the Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
December 1, 2004

1. The basic health benefit plan as defined by the Commissioner pursuant to 10-16-105(7.2)(b)(IV), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Health Benefit Plan without Specified Mandates*", "*Basic High Deductible Health Benefit Plan*", "*Basic High Deductible Health Benefit Plan without Specified Mandates*".

2. The standard health benefit plan for an indemnity, preferred provider, and HMO plan *shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan*." [Emphases added.]

Benefit Grids:

2004 COLORADO BASIC HEALTH BENEFIT PLANS WITHOUT SPECIFIED MANDATES: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	BASIC INDEMNITY PLAN	BASIC PREFERRED PROVIDER PLAN		BASIC HMO PLAN
BASIC HEALTH BENEFIT PLAN WITHOUT SPECIFIED MANDATES		IN-NETWORK	**OUT-OF-NETWORK [2]**	**IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.)
24. ORGAN TRANSPLANTS [18]	Covered transplants include: liver, heart, *heart/lung, lung*, cornea, kidney, *kidney/pancreas*, and bone marrow *for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.* [Emphases added.]			
	50% coinsurance	70% coinsurance	50% coinsurance	Coverage is no less extensive than the coverage for any other physical illness.

[18] Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

It appears that the Company is not in compliance with Colorado insurance law in that the description of covered transplant procedures contained in the Company's Basic Preferred Provider Conversion Health Benefit Plan of Colorado does not contain all of the transplant procedures required to be covered under the Basic and Standard health benefit plans.

The Company's form appears to fail to provide coverage for heart/lung, lung, and kidney/pancreas transplants. In addition, the Company's form fails to list the specific conditions that are mandated to be covered for bone marrow transplants and does not provide for peripheral stem cell support for the covered bone marrow transplants.

The Company's Basic Preferred Provider Conversion Health Benefit Plan of Colorado states in part the following:

Covered Expenses

> Charges made for or in connection with approved human-to-human organ transplant services, including immunosuppressive medication; organ procurement costs; and donor's medical costs. Organ transplants are limited to: liver; heart; kidney; cornea and bone marrow for aplastic anemia, leukemia, immunodeficiency disease and Wiskott-Aldrich syndrome. The amount payable for donor's medical costs will be reduced by the amount payable for those costs from any other Plan.
>
> Certain transplants will not be covered based on General Limitations. Contact CG before you incur any such costs.

Form	Form Number
Connecticut General Life Insurance Company Basic Preferred Provider Conversion Health Benefit Plan of Colorado	GM6000 C1 (COBPC)

Recommendation No. 1

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to properly display all transplant benefits mandated by Colorado insurance law.

Issue E2: Failure to properly title its Basic health benefit plan certificates.

Colorado Insurance Regulation 4-6-5, Concerning the Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

Section 4. Rules

A. 1. Basic Plan. T*he form and content of the basic health benefit plan may be one or more of the three plan design option as appended to this regulation and shall constitute the basic health benefit plan design* pursuant to Section 10-16-105 (7.2), C.R.S. At least one of these three plan design options shall be required for use in Colorado's small group market pursuant to Section 10-16-105 (7.3), C.R.S., and as conversion coverage pursuant to Section 10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic plan or to those individuals purchasing a basic conversion plan.

B. *The basic* and standard *health benefit plans shall be identified as specified below.*

1. Each small employer carrier shall title and market *its basic health benefit plan as follows*: "[Carrier name][Type of plan (i.e., Indemnity, Preferred Provider or HMO)] (Basic Health Benefit Plan *without Specified Mandates, Basic High Deductible Health Benefit Plan or Basic High Deductible Health Benefit Plan without Specified Mandates*)] for Colorado." [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its Connecticut General Life Insurance Company Basic Preferred Provider Conversion Health Benefit Plan of Colorado is not correctly titled. The title does not include the words "without Specified Mandates" or "High Deductible".

Form	Form Number
Connecticut General Life Insurance Company Basic Preferred Provider Conversion Health Benefit Plan of Colorado	GM6000 C1 CER1 M

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its forms to properly title them in accordance with Colorado insurance law.

CLAIMS

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time frames required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

> (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.
>
> (4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.*
>
> (b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.
>
> *(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphases added.]

ELECTRONIC CLAIMS PROCESSED OVER 30 CALENDAR DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
3,937*	50	30	60%

(*2% of all electronic paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) electronic claims from a total summarized population of 3,937 electronic claims that had not been paid, denied or settled within thirty (30) calendar days after receipt. It appears the Company is not in compliance with Colorado insurance law in that thirty (30) of the electronic claims in the sample, while appearing to be clean claims, were not paid, denied, or settled within thirty (30) calendar days after receipt.

NON-ELECTRONIC CLAIMS PROCESSED OVER 45 CALENDAR DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,580*	50	28	56%

(*5% of all non-electronic paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) non-electronic claims from a total summarized population of 2,580 non-electronic claims that had not been paid, denied or settled within forty-five (45) calendar days after receipt. It appears that the Company is not in compliance with

Colorado insurance law in that twenty-eighty (28) of the non-electronic claims in the sample, while appearing to be clean claims, were not paid, denied, or settled within forty-five (45) calendar days after receipt.

CLAIMS PROCESSED OVER 90 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,440*	50	30	60%

(*1% of all paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) claims from a total summarized population of 2,440 claims that had not been paid, denied or settled within ninety (90) calendar days after receipt. It appears the Company is not in compliance with Colorado insurance law in that thirty (30) of the claims in the sample were not paid, denied or settled within the required ninety (90) calendar days after receipt.

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that all claims are paid, denied, or settled within the time frames required by Colorado insurance law.

Issue J2: Failure, in some instances, to pay interest and/or penalty on claims not processed within the time frames required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states in part:

(4) (a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. …

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5) (a) *A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.*

(b) *A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.* [Emphases added.]

ELECTRONIC CLAIMS PROCESSED OVER 30 CALENDAR DAYS
PAYMENT OF INTEREST

Population	Sample Size	Number of Exceptions	Percentage to Sample
3,937*	50	27	54%

(*2% of all electronic paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) electronic claims from a total summarized population of 3,937 electronic claims that had not been paid, denied or settled within thirty (30) days after receipt. It appears the Company is not in compliance with Colorado insurance law in that it failed to pay interest to either the provider or the insured on twenty-seven (27) clean electronic claims that were not paid, denied or settled within thirty (30) calendar days after receipt.

NON-ELECTRONIC CLAIMS PROCESSED OVER 45 CALENDAR DAYS
PAYMENT OF INTEREST

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,580*	50	18	36%

(*5% of all non-electronic paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) non-electronic claims from a total summarized population of 2,580 non-electronic claims that had not been paid, denied or settled within forty-five (45) calendar days after receipt. It appears the Company is not in compliance with Colorado insurance law in that it failed to pay interest to either the provider or the insured on eighteen (18) clean non-electronic claims that were not paid, denied or settled within forty-five (45) calendar days after receipt.

CLAIMS PROCESSED OVER 90 CALENDAR DAYS - PAYMENT OF PENALTY

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,440*	50	16	32%

(*1% of all paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) claims from a total summarized population of 2,440 claims that had not been paid, denied or settled within ninety (90) calendar days after receipt. It appears the Company is not in compliance with Colorado insurance law in that it failed to pay a ten percent (10%) penalty on the total amount ultimately allowed on the claim to the insured or health care provider on sixteen (16) of the claims not paid, denied, or settled within ninety (90) calendar days after receipt.

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that interest is paid on clean claims that are not paid, denied, or settled within the time frames required by Colorado insurance law and that, except where fraud is involved, a penalty is paid on all claims not paid, denied, or settled within ninety (90) calendar days after receipt as required by Colorado insurance law.

Issue J3: Failure, in some instances, to pay eligible claims.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:
>
> (IV) Refusing to pay claims without conducting a reasonable investigation based upon all available information; or
>
> (VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; …

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

> (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of the section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

DENIED CLAIMS SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
14,453	100	6	6%

From a population of 14,453 claims denied by the Company between January 1, 2005 and December 31, 2005, a randomly selected sample of 100 denied claims was reviewed.

It appears that the Company is not in compliance with Colorado insurance law in that at the time six (6) claims were denied, the Company was in possession of all information necessary for it to pay the claims, which were covered under the terms of the contract.

- Three (3) claims were incorrectly denied for unknown reasons;
- Two (2) claims were incorrectly denied as being not covered; and
- One (1) claim was incorrectly denied for exceeding plan coverage.

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104 and 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has reviewed and modified its quality controls to ensure that its claims processing staff is properly trained to make appropriate decisions and thus avoid denying eligible claims to assure compliance with Colorado insurance law.

UTILIZATION REVIEW

Issue K1: Failure, in some instances, to provide written notification of standard utilization review adverse determinations.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 6. Standard Utilization Review

B.(1)(a)(i) Subject to Subparagraph (b) of this paragraph, for prospective review determinations, *a health carrier shall* make the determination and *notify the covered person and the covered person's provider of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than fifteen (15) days after the date the health carrier receives the request.*

(ii) *Whenever the determination is an adverse determination, the health carrier shall make the notification of the adverse determination in accordance with Subsection E.*

E.(1) A notification of an adverse determination under this section shall, in a manner set calculated to be understood by the covered person, set forth:

(1) A health carrier must provide the notice required under this section in writing, either on paper or electronically. [Emphases added.]

STANDARD UTILIZATION REVIEW ADVERSE DETERMINATIONS
WRITTEN NOTIFICATION

Population	Sample Size	Number of Exceptions	Percentage to Sample
90	43	4	9%

The examiners reviewed a randomly selected sample of fifty (50) HMO standard utilization review adverse determination files. Of the fifty (50) files identified for review, the Company was unable to provide documentation on five (5) of the files. Additionally, two (2) of the files selected for review were determined to be utilization review determinations that were approved by the Company. As a result, the effective sample size was forty-three (43) files. It appears that the Company did not meet the requirements of Colorado insurance law in that in four (4) of the files reviewed, the examiners were unable to find any documentation that written notification of the adverse determination was provided to either the covered person, or the covered person's provider.

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that written notification is provided for all utilization review adverse determinations as required by Colorado insurance law.

Issue K2: Failure, in some instances, to include all required information in the written notice of first level appeal decisions.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 10. First Level Review

J. A first level review decision involving an adverse determination issued pursuant to Subsection G shall include, in addition to the requirements of Subsection I:

(6) If the carrier offers a voluntary second level appeal, a description of the process to obtain a voluntary second level review, including:

(b) The right of the covered person to:

(i) Request the opportunity to appear in person before a review panel of the health carrier's designated representatives;
(ii) Receive from the health carrier, upon request, copies of all documents, records and other information that is not confidential or privileged relevant to the covered person's request for benefits;
(iii) Present the covered person's case to the review panel;
(iv) Submit written comments, documents, records and other material relating to the request for benefits for the review panel to consider when conducting the review both before and, if applicable, at the review meeting;
(v) If applicable, ask questions of any representative of the health carrier on the review panel; and
(vi) Be assisted or represented by an individual of the covered person's choice;

(c) A statement that the carrier will provide the covered person, upon request, sufficient information relating to the voluntary second level review to enable the claimant to make an informed judgment about whether to submit the adverse determination to a voluntary second level review, *including a statement that the decision of the covered person as to whether or not to submit the adverse determination to a voluntary second level review will have no effect on the covered person's rights to any other benefits under the plan, the process for selecting the decision maker, and the impartiality of the decision maker*.

(d) A description of the procedures for obtaining an independent external review of the adverse determination pursuant to insurance regulation 4-2-21 if the covered person chooses not to file for a voluntary second level review of the first level review decision involving an adverse determination. [Emphases added.]

LEVEL 1 APPEALS – Second Level Appeal Rights

Population	Sample Size	Number of Exceptions	Percentage to Sample
90	31	12	39%

LEVEL 1 APPEALS – Rights to Other Benefits Under the Plan

Population	Sample Size	Number of Exceptions	Percentage to Sample
90	31	12	39%

LEVEL 1 APPEALS – Obtaining Independent External Review

Population	Sample Size	Number of Exceptions	Percentage to Sample
90	31	12	39%

The examiners reviewed a randomly selected sample of fifty (50) HMO utilization review first level appeal files initiated by covered persons or their representatives. Of the fifty (50) files reviewed, thirty-one (31) involved adverse first level appeal decisions. The Company offers a voluntary second level appeal process. It appears that the Company did not meet the requirements of Colorado insurance law in that:

- In twelve (12) out of thirty-one (31) adverse first level appeal determination files reviewed, the Company's first level appeal decision notification letter did not contain a statement fully outlining the covered person's second level appeal rights as set forth in Colorado Insurance Regulation 4-2-17(10)(J)(6)(b).

- In twelve (12) out of thirty-one (31) adverse first level appeal determination files reviewed, the Company's first level appeal decision notification letter did not contain a statement of the covered person's rights as set forth in Colorado Insurance Regulation 4-2-17(10)(J)(6)(c).

- In twelve (12) out of thirty-one (31) adverse first level appeal determination files reviewed, the Company's first level appeal decision notification letter did not contain a statement of procedures for obtaining an independent external review of the adverse first level appeal determination as set forth in Regulation 4-2-17(10)(J)(6)(d).

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that first level appeal decision notification letters include all information as required by Colorado insurance law.

Issue K3: Failure, in some instances, to provide the title and qualifying credentials of the physician reviewer in first level appeal notification letters.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

> Section 10. First Level Review
>
> I. The decision issued pursuant to Subsection G shall set forth in a manner calculated to be understood by the covered person:
>
> (1) *The name, title and qualifying credentials of the physician evaluating the appeal*, and the qualifying credentials of the clinical peer(s) with whom the physician consults. (For purposed of this section, the physician and consulting clinical peers shall be called "the reviewers".) [Emphasis added]

LEVEL 1 APPEALS – Title and Qualifying Credentials

Population	Sample Size	Number of Exceptions	Percentage to Sample
90	31	8	26%

The examiners reviewed a randomly selected sample of fifty (50) HMO utilization review first level appeal files initiated by "covered persons" or their representatives. Of the fifty (50) files reviewed, thirty-one (31) were adverse determinations that required disclosure of the title and qualifying credentials of the reviewing physician.

It appears that the Company did not meet the requirements of Colorado insurance law in that in eight (8) out of thirty-one (31) first level appeal files reviewed, the Company's first level appeal decision notification letter did not contain the title and qualifying credentials of the physician that evaluated the appeal request as set forth in Colorado Insurance Regulation 4-2-17(10)(I)(1).

Note: Although Colorado Insurance Regulation 4-2-17(10)(I)(1) mandates disclosure of the name, title and qualifying credentials of the reviewing physician, along with the qualifying credentials of the peer reviewer of all first level appeals, the examiners are not citing the Company for failure to do so in the appeals that resulted in a reversal of the original utilization review decision. It was felt that these determinations were in the interest of the consumer. However, the Company should take steps to ensure that its first level appeal practices conform to Colorado insurance law whether the original adverse utilization review determination is upheld or reversed.

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that written notifications of first level appeal decisions contain all information required by Colorado insurance law.

Issue K4: Failure, in some instances, to consult with an appropriate clinical peer in reviewing first level utilization review appeals.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 4. Definitions

D. "Clinical peer" means a physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

Section 10. First Level Review

E. (1) First level reviews shall be evaluated by a physician *who shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer*. The physician and clinical peer(s) shall not have been involved in the initial adverse determination. However, a person that was previously involved with the denial may answer questions. [Emphasis added.]

LEVEL 1 APPEALS – Appropriate Clinical Peer

Population	Sample Size	Number of Exceptions	Percentage to Sample
90	31	2	6%

The examiners reviewed a randomly selected sample of fifty (50) HMO utilization review first level appeal files initiated by covered persons or their representatives. Of the fifty (50) files reviewed, thirty-one (31) were adverse determinations that required a consultation with a clinical peer.

It appears that the Company did not meet the requirements of Colorado insurance law in that in two (2) out of thirty-one (31) first level appeal files reviewed, the first level appeal review by the Company did not involve consultation with an appropriate clinical peer, nor did the reviewing physician appear to be a "clinical peer" as set forth in Colorado Insurance Regulation 4-2-17(10)(E)(1).

Note: Although Colorado Insurance Regulation 4-2-17(10)(E)(1) mandates an appropriate clinical peer consultation of all first level appeals of an adverse utilization review determination, the examiners are not citing the Company for failure to do so in the appeals that resulted in a reversal of the original utilization review decision. It was felt that these determinations were in the interest of the consumer. However, the Company should take steps to ensure that its first level utilization review appeal practices conform to Colorado insurance law whether the original adverse utilization review determination is upheld or reversed.

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its policies and procedures to ensure that utilization review first level appeals meet the requirements of Colorado insurance law.

Issue K5: Failure to disclose and/or provide the names, titles and/or credentials of the voluntary second level utilization review panel.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 11. Voluntary Second Level Review

H. A decision issued pursuant to Subsection G shall include:

(2) *The names,* titles and qualifying credentials *of the review panel*…
[Emphasis added]

VOLUNTARY SECOND LEVEL APPEALS – Names, Titles and Credentials of Review Panel

Population	Sample Size	Number of Exceptions	Percentage to Sample
9	7	7	100%

The examiners reviewed the entire population of the Company's voluntary second level utilization review appeal files initiated by covered persons or their representatives. Of the nine (9) files reviewed, one (1) file was found to be a denial of benefits due to member ineligibility prior to scheduling the review panel and was therefore not included in the review. An additional appeal file contained a decision that was overturned prior to review by the review panel, and therefore was also not reviewed. The remaining seven (7) files were determinations that required disclosure of the names, titles and qualifying credentials of the members of the review panel.

It appears that the Company did not meet the requirements of Colorado insurance law in that in all seven (7) of the voluntary second level utilization review decisions reviewed, the Company's decision notification letter and/or attachment provided to the covered person and/or their representative(s), did not contain the names, titles, and/or qualifying credentials of the members of the review panel as required by Colorado Insurance Regulation 4-2-17(11)(H)(1).

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its policies and procedures to ensure that its voluntary second level utilization review meets the requirements of Colorado insurance law.

Issue K6: Failure, in some instances, to ensure that a majority of the voluntary second level appeal review panel is comprised of health care professionals with appropriate expertise.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 11. Voluntary Second Level Review

F.(2)(b) *A health carrier shall ensure that a majority of the persons* reviewing a grievance involving an adverse determination *are health care professionals who have appropriate expertise in relation to the case presented by the covered person.* [Emphasis added.]

VOLUNTARY SECOND LEVEL APPEALS – Make-Up of Review Panel

Population	Sample Size	Number of Exceptions	Percentage to Sample
9	7	2	29%

The examiners reviewed the entire population of nine (9) of the Company's voluntary second-level utilization review appeal files initiated by covered persons or their representative(s).

Of the nine (9) files reviewed, one (1) file was found to be a denial of benefits due to member ineligibility prior to scheduling the review panel and was therefore not included in the review. An additional appeal file contained a decision that was overturned prior to review by the review panel, and therefore was also not reviewed. The remaining seven (7) files were determinations that require that the majority of the Company's voluntary second level review panel be comprised of health care professionals with appropriate expertise relating to the case being reviewed.

It appears that the Company did not meet the requirements of Colorado insurance law in that in two (2) out of seven (7) voluntary second level utilization review decisions reviewed, the Company failed to ensure that the majority of the review committee was comprised of health care professionals with the appropriate expertise in relation to the case being presented by the covered person and/or their representative(s) as set forth in Colorado Insurance Regulation 4-2-17(11)(F)(2)(b).

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its policies and procedures to ensure that its voluntary second level review panel includes a majority of persons who are health care professionals with appropriate expertise in relation to the case being reviewed as required by Colorado insurance law.

Issue K7: Failure, in some instances, to provide notice of voluntary second level review scheduling to covered persons at least twenty (20) days prior to the scheduled review date.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 11. Voluntary Second Level Review

G. A health carrier's procedures for conducting a voluntary second level panel review shall include the following:

(1) The review panel shall schedule and hold a review meeting within sixty (60) days of receiving a request from a covered person for voluntary second level review. *The covered person shall be notified in writing at least twenty (20) days in advance of the review date.* The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person. [Emphasis added.]

VOLUNTARY SECOND LEVEL APPEALS – Notification of Review Panel Meeting

Population	Sample Size	Number of Exceptions	Percentage to Sample
9	8	6	75%

The examiners reviewed the entire population of nine (9) of the Company's voluntary second level utilization review appeal files initiated by covered persons or their representative(s).

Of the nine (9) files reviewed, one (1) file was found to be a denial of benefits due to member ineligibility prior to scheduling the review panel and was therefore not included in the review. The remaining eight (8) files were files that required notification to the covered person at least twenty (20) days prior to the scheduled review date.

It appears that the Company did not meet the requirements of Colorado insurance law in that in six (6) of the eight (8) files reviewed, the Company did not provide the covered person or their representative(s) notice of the scheduled review date at least twenty (20) days prior to the review date as required by Colorado Insurance Regulation 4-2-17(11)(G)(1).

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its policies and procedures to ensure that covered persons are notified in writing at least twenty (20) days in advance of the second level review date as required by Colorado insurance law.

Issue K8: Failure, in some instances, to not discourage covered persons (or their representative) from requesting a face-to-face voluntary second level utilization review meeting.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 11. Voluntary Second Level Review

A. A carrier may establish a voluntary review process to give those covered persons who are dissatisfied with the first level review decision the option to request a voluntary second level review, at which the covered person has the right to appear in person at the review meeting before designated representatives of the carrier. The procedures shall allow the covered person to identify providers to whom the health carrier shall send a copy of the review decision.

G. A health carrier's procedures for conducting a voluntary second level panel review shall include the following:

(2) *Carriers shall in no way discourage a covered person from requesting a face-to-face review meeting*. Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person, including accommodation for disabilities. In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology. [Emphasis added.]

VOLUNTARY SECOND LEVEL APPEALS – Request a Face-to-Face Meeting

Population	Sample Size	Number of Exceptions	Percentage to Sample
9	8	8	100%

The examiners reviewed the entire population of nine (9) of the Company's voluntary second level utilization review appeal files initiated by covered persons or their representative(s).

Of the nine (9) files reviewed, one (1) file was found to be a denial of benefits due to member ineligibility prior to scheduling the review panel and was therefore not included in the review. The remaining eight (8) files were cases where the review panel was scheduled.

It appears that the Company did not meet the requirements of Colorado insurance law in that in all eight (8) of the files reviewed, the Company discouraged the covered person and/or their representative(s) from requesting a face-to-face meeting by not fully disclosing the location of the review panel meeting, or stating that the location is "teleconference".

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its policies and procedures to ensure that it does not discourage covered persons (or their representatives) from requesting and/or attending voluntary second level utilization review panel meetings in person as required by Colorado insurance law.

SUMMARY OF ISSUES AND RECOMMENDATIONS	Rec. No.	Page No.
CONTRACT FORMS		
Issue E1: Failure of forms to properly define and/or list the mandated transplant benefits in its Basic and Standard health benefit plan certificates.	1	15
Issue E2: Failure to properly title its Basic health benefit plan certificates.	2	16
CLAIMS		
Issue J1. Failure, in some instances, to pay, deny, or settle claims within the time frames required by Colorado insurance law.	3	19
Issue J2: Failure, in some instances, to pay interest and/or penalty on claims not processed within the time frames required by Colorado insurance law.	4	21
Issue J3. Failure, in some instances, to pay eligible claims.	5	23
UTILIZATION REVIEW		
Issue K1. Failure, in some instances, to provide written notification of standard utilization review adverse determinations.	6	25
Issue K2. Failure, in some instances, to include all required information in the written notice of first level appeal decisions.	7	27
Issue K3. Failure, in some instances, to provide the title and qualifying credentials of the physician reviewer in first level appeal notification letters.	8	28
Issue K4. Failure, in some instances, to consult with an appropriate clinical peer in reviewing first level utilization review appeals.	9	29
Issue K5: Failure to disclose and/or provide the names, titles and/or credentials of the voluntary second level utilization review panel.	10	30
Issue K6: Failure, in some instances, to ensure that a majority of the voluntary second level appeal review panel is comprised of health care professionals with appropriate expertise.	11	31
Issue K7: Failure, in some instances, to provide notice of voluntary second level review scheduling to covered persons at least twenty (20) days prior to the scheduled review date.	12	32
Issue K8: Failure, in some instances, to not discourage covered persons (or their representative) from requesting a face-to-face voluntary second level utilization review meeting.	13	34

State Market Conduct Examiners

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC
David M. Tucker, AIE, FLMI, ACS
John E. Bell

For

The Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202

Participated in this examination and in the preparation of this report.